	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMPI	
		HAL054062	B. WING		02/0	₹ 3/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KINSTO	N ASSISTED LIVING		SE VISTA RO , NC 28504	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
{C 000}	Initial Comments		{C 000}			
	S. Bryant and Greg	Up Survey conducted by Billy Cates on 02/03/2016.  The Biennial Survey on to be corrected.				
{C 137}	Bathrooms-Nonskid	d Strips in Showers	{C 137}			
	rooms are:	05 PHYSICAL  Ints for bathrooms and toilet cing or strips shall be installed				
	ensure that the sho skid-resistant surface who may use the sh slipping on the slick	ation, the facility failed to wer floor is equipped with a ce. This affects all residents nower by not preventing floor.				
		2016: he group Bathrooms are not skid surfaces or strips				
{C 164}	Housekeeping and	Furnishings-Clean, Repaired	{C 164}			
	FURNISHINGS (a) Adult care home (1) have walls, ceil coverings kept clea (2) have no chronic (3) have furniture of	es shall: ings, and floors or floor n and in good repair;				

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION 01		PLETED	
		HAL054062	B. WING			R 03/2016
	PROVIDER OR SUPPLIER	2130 ROS	DRESS, CITY, S E VISTA RO , NC 28504	STATE, ZIP CODE AD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
{C 164}	facilities.  This Rule is not me 1. Based on Observe kept clean and in go building component originally intended of affect all residents, component does not limiting use of equiparties.  Findings on 02/03/2 a. In bedroom 213 to was loose.  b. Many of the hollo doors that are in the scuffed-up.  2. Based on Observe have walls, ceilings kept clean and in go Findings on 02/02/2 a. The carpet was stollowing locations to Central Corridor necentral Cor	et as evidenced by: vation, the Building was not cood repair, because some its failed to function as or are missing. This could staff and visitors if a of work properly or is missing oment/spaces.  2106: the window sill (blue stone)  ww-core closet and toilet rooms is bedrooms are very  vation, the facility failed to , and floors or floor coverings, cood repair.  2016: stained, and dirty at the to include but not limited to: ar Employee Only Room, ar Office, ar Kitchen ar Dining,  O Hall firewall.  was dirty with an t, stains and grease deposits of the floor and around	{C 164}			

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION  01	(X3) DATE COMP	SURVEY LETED
		HAL054062	B. WING		02/0	R 3/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KINSTON	N ASSISTED LIVING		SE VISTA RO , NC 28504	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
{C 164}	Continued From pa	ge 2	{C 164}			
	disrepair					
	d. The carpet at the worn away.	door to Bedroom 102 was				
		03/2016: nt bathrooms surveyed all aning of the tiled bathroom				
		vation, the facility failed to clean and in good repair.				
	Findings on 02/03/2 a. In the Dining Roo missing its plastic la	om, the built-in counter was				
	were having one or following issues: mi	inet in the residents rooms any combination of the issing drawers, drawers would s, fronts are missing, dirty,				
	c. Many of the night	tstands need refinishing.				
	originally secure to	acility, the mirrors were their vertical surfaces with six secure the mirrors is in mplete.				
	New Finding on 02/ a. The built-in cabin need to pull knobs	net in the residents' rooms				
{C 166}	Housekeeping-Mair	ntained Free of Hazards	{C 166}			
	SECTION .0300 - F 10A NCAC 13F .03	PHYSICAL PLANT 06 HOUSEKEEPING AND				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
					F	₹
		HAL054062	B. WING		02/0	3/2016
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
KINSTO	N ASSISTED LIVING		E VISTA RO , NC 28504	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
{C 166}	Continued From pa	ge 3	{C 166}			
	orderly manner, fre hazards;	es shall: n an uncluttered, clean and e of all obstructions and apply to new and existing				
	This Rule is not met as evidenced by:  1. Based on Observation, the facility failed to provide an environment in accordance with this Rule. This rule is not being met because facility equipment is not being maintained in a safe operating manner. This would affect all residents, staff and visitors, if equipment in disrepair injury someone.					
	Findings on 02/03/2 a. The over-the-bed the wall in Bedroom	l light was loosely attached to				
	b. An electrical pow Laundry had a brok	er receptacle in the Bulk en cover plate.				
	c. The Kitchen Hoo missing its cover pl	od gas cutoff valve was ate.				
	d. In the Freezer the missing its cover pl	e refrigeration equipment was ate.				
		en stove there appears to be box missing its cover plate.				
	g. The globe to the was missing.	light fixture in Bedroom 101				
	fan on the rear build	03/2016:  uit for the centrifugal exhaust ding roof is detached from the ox and the electrical wiring is				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE S COMPL	
			A. BOILDING.	VI	R	,
		HAL054062	B. WING			3/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
KINSTO	ASSISTED LIVING		E VISTA RO. , NC 28504	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
{C 166}	Continued From pa	ge 4	{C 166}			
	exposed					
	equipment was not by not have properl This could affect all not protecting them broken or missing p	016: of the commode to the floor				
{C 175}	Bedroom Furnishin	gs-Clean Towel, Towel Bar	{C 175}			
	FURNISHINGS (b) Each bedroom s furnishings in good resident: (7) individual clean bar in the bedroom	PHYSICAL PLANT 06 HOUSEKEEPING AND shall have the following repair and clean for each towel, wash cloth and towel or an adjoining bathroom; and apply to new and existing				
	provide residents a	et as evidenced by: rvation, the facility failed to reas, with the required id/or towel bars for each				
		including the adjoining toilet de a means for each resident				
{C 185}	Fire Safety-Rehear	sals on Each Shift	{C 185}			

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION 01	(X3) DATE COMP	SURVEY LETED
					F	₹
		HAL054062	B. WING		02/0	3/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KINSTO	N ASSISTED LIVING		E VISTA RO , NC 28504	AD		
(V4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	)N	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE	COMPLETE DATE
{C 185}	Continued From pa	ge 5	{C 185}			
	SECTION .0300 - F 10A NCAC 13F .03 EVACUATION (b) There shall be a quarterly on each s requirement of the Enforcement Officia (c) Records of rehe and copies furnishes social services anninclude the date and shift, staff members description of what (f) This Rule shall a facilities. This Rule is not me 1. Based on Record Executive Director of document the rehea all residents, staff a trained staff and trained the staff and trained staff and t	PHYSICAL PLANT 09 PLAN FOR  rehearsals of the fire plan hift in accordance with the local Fire Prevention Code al. earsals shall be maintained ed to the county department of ually. The records shall d time of the rehearsals, the s present, and a short the rehearsal involved. apply to new and existing  et as evidenced by: d review and interview with the facility failed to adequately arsals. This deficiency affects and visitors by not having hined/cooperative residents ed to evacuate the building.				
	Finding on 02/03/20 a. The fire plan reheavailable for review	earsal documents were not				
{C 188}	Electrical Outlets in	Wet Locations	{C 188}			
	All adult care home locations at sinks, b	PHYSICAL PLANT  10 ELECTRICAL OUTLETS  1 electrical outlets in wet  10 pathrooms and outside of  11 ground fault interrupters.				
	This Rule is not me 1. Based on Observ	et as evidenced by: vation, the facility failed to				

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	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SUPPLIER OF COMPLET (X3) DATE SUPPLIER OF COMPLET (X4) PROVIDER OF COMPLET (X5) DATE SUPPLIER OF COMPLET (X6) DATE SUPPLIER OF COMPLET (X7) DATE SUPPLIER OF C					
		HAL054062	B. WING		F-02/0	R 3/2016
NAME OF I	PROVIDER OR SUPPLIER		DRESS CITY S	STATE, ZIP CODE	1 02/0	372010
	N ASSISTED LIVING		E VISTA RO			
KiitoTol			NC 28504			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
{C 188}	Continued From pa	ge 6	{C 188}			
	receptacles in wet a residents, staff and	nanner, the electrical power areas. This would affect all visitors by not providing ion to these devices.				
	electrical power rec of the test button ar	circuit-interrupter (GFCI) eptacle did not trip with a push nd when tested with a circuit om near Bedroom 270. The				
	six feet of wet areas	wer receptacles that are within s did not provide ground fault lowing locations to include but pom 211.				
	electrical power rec test button was pus to include but not lir	circuit-interrupter (GFCI) eptacle did not reset after the hed at the following locations mited to: the Health and Wellness				
	electrical power rec power and could no	circuit-interrupter (GFCI) eptacle did not have electrical of the tested for ground faults at ons to include but not limited				
{C 189}	Building Equipment	Maintained Safe, Operating	{C 189}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION 01		E SURVEY PLETED	
		HAL054062	B. WING			R <b>03/2016</b>
	PROVIDER OR SUPPLIER N ASSISTED LIVING	2130 ROS	DRESS, CITY, S SE VISTA RO I, NC 28504	STATE, ZIP CODE <b>AD</b>		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
{C 189}	care home shall be operating condition. (k) This Rule shall facilities with the ex which shall not app.  This Rule is not me 1. Based on record was not being main.  Findings on 02/03/2 a. In accordance wi an Annual Fire Alart Testing Report was several deficiencies addressed.  b. Fire alarm inspector review.  2. Based on Observial maintained in a safe doors that did not contain smoke and residents, staff and smoke and fire in the Findings on 02/03/2 a. The back leaf of doors did not latch alarm system.  3. Based on observing maintained in a safe because the exit significant informatical in residents, staff all residents.	maintained in a safe and apply to new and existing ception of Paragraph (e) by to existing facilities.  et as evidenced by: review, the fire alarm system tained.  2016: th NFPA 72 on April 1, 2015, m System Inspection and performed. The report listed that have not been better that have not been better that the performed are manner by having fire rated lose completely in order to fire. This could affect all visitors by not containing the fire compartment of origin.	{C 189}			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					(X3) DATE COMP	SURVEY LETED
					F	3
		HAL054062	B. WING			3/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
KINSTO	N ASSISTED LIVING		E VISTA RO , NC 28504	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
{C 189}	Continued From pa	ge 8	{C 189}			
	when tested. Locati include but are not Central Corridor ex Corridor near Bedro 4. Based on Observation as a semble duration as originall all residents, staff a assembly does not contain smoke/fire compartment of originally as a semble of the compartment of original semble of the compartment of	d not work on backup power fons of specific examples limited to: it near Back Activity Room, foom 114.  Vation, the Building was not e and operating condition, ding components fail to y intended. This could affect and visitors if the component or function properly and cannot in the room or fire gin  2016: the corridor door, requires effect to open because the				
	the floor.	is jamb allow the door the hit e door is scraping the floor				
	and cannot be easi					
	maintained in a safe because breaches fire-resistance-rate integrity. This could	d construction invalidated its affect all residents, staff and e is not contained in Room or				
	penetrated the one- ceiling. Note: The c	2016: Indicate the description of the description o				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION 01	(X3) DATE COMPI	SURVEY LETED
		HAL054062	B. WING		02/0	R 3/2016
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 02/0	0,2010
KINSTO	N ASSISTED LIVING		E VISTA RO NC 28504	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
{C 189}	fire-resistance-rated were removed in the 6. Based on Observation maintained accessing Findings on 02/03/2 a. The survey did not areas:  Tammy's Office Beth's Office Business Office	d ceiling were light fixtures e Exterior Electrical Room.  vation, the Building was not ble for inspection.	{C 189}			
{C 197}	SECTION .0300 - F 10A NCAC 13F .03 REQUIREMENTS (f) In addition to the minimum lighting sh (1) 30 foot-candle p (2) 10 foot-candle p (k) This Rule shall facilities with the ex which shall not app  This Rule is not me 1. Based on obsermaintain in an operative egress pathway residents, staff and were not illuminated  Finding on 02/03/21	e required emergency lighting, nall be as follows: power for reading; power for general lighting; and apply to new and existing ception of Paragraph (e) by to existing facilities. The as evidenced by: evation, the facility failed to ating manner illumination of st. This would affect all visitors if the egress pathways d.	{C 197}			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION 01	(X3) DATE COMP	SURVEY LETED	
		HAL054062	B. WING		02/0	R 3/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 02/0	3/2010
	N ASSISTED LIVING		E VISTA RO			
KINSTO	N ASSISTED LIVING	KINSTON	NC 28504			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
{C 199}	Continued From pa	ge 10	{C 199}			
{C 199}	Exhaust Ventilation		{C 199}			
	provided with exhautwo cubic feet per narequirement does no before April 1, 1984 these specified spa (1) soiled linen stor (2) soil utility room; (3) bathrooms and (4) housekeeping (5) laundry area. (k) This Rule shall facilities with the exwhich shall not apple. This Rule is not med 1. Based on Obsefailed to maintain the working order. This and visitors by subjections.	ed in this Paragraph shall be ust ventilation at the rate of ninute per square foot. This ot apply to facilities licensed, with natural ventilation in ces: rage; toilet rooms; closets; and apply to new and existing ception of Paragraph (e) ly to existing facilities. et as evidenced by: rvation and testing the facility is eventilation system in proper could affect all residents, staff ecting them to odors.				

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